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CLINICAL LECTURES AND REPORTS.

LECTURES

*Delivered in the Theatre of St. George's Hospital, in
the session 1843-44,*

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Fistula in ano. Ulceration of the intestinal mucous membrane. Cases of ulceration and perforation of the intestinal canal. Fistula in ano caused by ulceration of the rectum. Causes of the ulceration. Symptoms of abscess near the anus. Situation of the orifices. Treatment. Ward's paste. Operation.

GENTLEMEN,—I presume that you are all aware of the fact that abscesses are very liable to form in the vicinity of the rectum, and that when so formed they heal only with considerable difficulty, and, for the most part, do not heal spontaneously. You are also aware that the parietes of these abscesses contract, and become hard and callous, in which stage the disease takes the name of *fistula in ano*.

Now, this affection, although of frequent occurrence in hospital practice, is much more common in private practice, and, therefore, it is, in every point of view, a disease of great interest to the surgeon.

The first question that presents itself is this,—Why is it that abscesses are so particularly liable to form in the situation in question, and that when so formed they do not heal like abscesses occurring in other parts of the cellular membrane? I formerly supposed that the healing process was prevented chiefly by the irregular action of the sphincter and levator ani muscles. Further consideration, however, and more mature experience, have lead me to the conclusion that this opinion was incorrect. That such causes may interfere with the healing of any abscess I well know, but I am now fully satisfied that they will not afford sufficient explanation why it so rarely happens that abscesses near the rectum heal spontaneously, and at any rate, it is quite clear that the action of these muscles will not explain the formation of these abscesses. In order to explain their formation I must call attention to what happens in other parts of the intestinal canal. The mucous membrane, under a variety of circumstances, is liable to ulcerate. In patients who die from diseased liver, or phthisis pulmonalis, or at the end of continued fever, and various other diseases, you find the mucous membrane of the bowels ulcerated. This ulceration seldom extends further, does not involve the muscular tunic, but sometimes the latter is affected, and then some of the contents of the intestines escape. Should this occur where the intestine is covered by peritoneum the contents may escape into the peritoneal cavity. For example, there was a little boy, seven years of age, who had symptoms of mesenteric disease, and who had just recovered from what was supposed to be a fever. When he appeared to be convalescent he was suddenly seized one evening with what was called a fainting fit, in

which his pulse was not perceptible. After some time, under the influence of a stimulant, he recovered; nevertheless, he continued low and depressed. On the following day he had another attack of the same kind, from which he did not rally, and on examining the body after death I found that there was ulceration on the inner surface of the ileum, and that the mesenteric glands were diseased. In one place the ulcer had extended by a small opening through the muscular tunic, and also through the peritoneum, and a small quantity of the feculent matter had escaped into the cavity of the belly. Every person who has had much experience of disease has seen cases of the same kind; but there are others in which both the muscular tunic and the peritoneal coat ulcerate, and yet the contents of the intestine do not escape into the cavity. Adhesions take place round the ulcerated spot before the ulceration of the peritoneal coat is completed, and these adhesions cause the contents to escape, not into the peritoneal cavity, but to become infiltrated into the cellular membrane of some part of the abdominal parietes. A young man, of seventeen or eighteen years of age, who had long been in ill-health from disease of the lungs, and who was indisposed in other ways, was supposed to be rather better than usual, but one evening he was seized with violent pain in one side, and there was considerable tenderness of the whole of the abdomen. Two physicians were sent for; the symptoms were not exactly those of peritoneal inflammation, but they could not explain the symptoms so well in any other way as by assuming that he laboured under peritoneal inflammation. The inflammatory symptoms subsided, and two or three months afterwards I was called in to see him on account of a tumour which had formed in the front of the belly. It was an abscess; I opened it, and there came out pus, and with it a good deal of foreign matter, which I was satisfied must have come from the intestinal canal. The abscess made its way in several other places, and ultimately this young man died. On examining the body after death it was found that there were ulcerations at the lower part of the ileum; one of these ulcers had extended through the muscular and peritoneal tunics, but around that ulcer the ileum had contracted adhesions to the abdominal parietes above the groin, and the matter had escaped into the cellular membrane between the layers of the abdominal muscles, and from thence had made its way forward to the part where I opened it. This patient died, but it is not a matter of course that, under such circumstances, such should be the result. I was called in to see a little boy who had been supposed to labour under mesenteric disease, and I found that there was an abscess near the umbilicus, discharging pus and feculent matter. We attended to his general health, kept him in a recumbent position, lying on his back, which, I apprehend, was a most essential part of the treatment. Some very simple dressing was applied to the opening, and the boy ultimately recovered. I do not know whether he is still alive, but he was alive two or three years afterwards. I saw another case of the same kind,

and I know that the boy lived a considerable time, but as he was taken away from London I cannot tell whether he ultimately recovered or not.

That part of the intestine in which ulceration of this kind is most likely to take place is the lower part of the ileum, but it not unfrequently occurs in the cæcum. Abscesses in the right iliac region generally belong to the cæcum. A young man, on jumping from a coach, felt something, as he said, give way in the right groin, and he came to London with a tumour in that situation. I thought that there was a deep-seated gland which was suppurating, and recommended him to go home, to keep quiet, and to poultice the tumour. A month after he had jumped from the coach he sent to say that the abscess had burst. There was a discharge of pus from it, but it was of a very offensive character, and on examining it carefully I was satisfied that there were faeces mixed with it. He had no bad symptoms at first, and being a very nervous man I did not tell him the exact nature of the case lest it should alarm him. Two or three days afterwards he took some medicine, and a draught of decoction of bark. A short time after, to his horror, the decoction of bark ran from the groin and frightened him out of his wits. From that moment his nervous system began to give way, he became in a state of great nervous excitement, and died ten days after the bursting of the abscess.

On a post-mortem examination I found an ulcerated opening of the cæcum; the faeces had escaped through it into the cellular membrane at the posterior part of the cæcum, and formed an abscess, which burst into the groin. There was a woman in this hospital, with an abscess in the groin, and we supposed it to be connected with dead bone, which is the case with a great number of chronic abscesses. Perhaps sufficient attention was not paid to the quality of the discharge; but one day the woman, in taking off a poultice, found in it a lumbricus. She ultimately died, and on examining the body after death we found an ulcerated opening of the cæcum through which this intestinal worm had made its way. It was evident that the ulcerated opening of the cæcum, which was at the posterior part, had been the beginning of the abscess. Though these cases are not exceedingly rare, I mention them, because stating specific cases will often impress an important fact on the mind much more than a general observation.

I believe that this is the way in which fistulæ in ano are always formed, namely, the disease is originally an ulcer of the mucous membrane of the bowel, extending through the muscular tunic into the cellular membrane external to the intestine; and I will state my reasons for entertaining that opinion. The matter is one of great interest as a question of pathology, but it is one of great importance, as I shall show by and by, in connection with surgical practice. It is admitted by every one that in the greater number of cases of fistulæ in ano there is an inner opening to the gut as well as the outer opening; and I am satisfied that the inner opening always exists, because I scarcely ever fail to find it, now that I look for it in the proper place and seek it carefully. I have, in a dead body, examined the parts where fistulæ had existed several times, and in every instance I have found an inner opening to it. This affords a very reasonable explanation of the formation of these abscesses; it is almost impossible to understand, on any other ground, why suppuration should take place in the vicinity of the rectum more than in any other part of the body, and why the cellular membrane there should suppurate more than cellular membrane elsewhere. Moreover, the pus con-

tained in an abscess near the rectum scarcely ever presents the appearance of laudable pus,—it is always dirty-coloured and offensive to the smell,—sometimes highly offensive, and occasionally you find feculent matter in it quite distinct. There is no reason why an abscess simply formed in the cellular membrane should smell of sulphuretted hydrogen; but there is a good reason why it should do so if it be connected with the rectum.

This being the case, it is easy to understand why these abscesses do not heal. The least quantity of mucus even from the gut, or of feculent matter, issuing into the cavity of the abscess, is sufficient to occasion irritation and prevent it healing, and I have more than once, in the living person, been able to trace the progress of the formation of one of these abscesses. For example, I was sent for to see a lady who complained of some irritation about the rectum, and on examining it I found an ulcer at the posterior part. I ordered her to take Ward's paste, consec. piperis nigrum, or cubeb's pepper, I forget which. A month afterwards she again sent for me, and I found that there was an abscess. I opened it, and from the outer opening the probe passed into the gut through the ulcer which had been the original cause of the disease. The original opening of the abscess is generally very small indeed, but occasionally it is large, and when the ulceration has proceeded to some extent, large enough to admit the end of the little finger. The inner orifice is, I believe, always situated immediately above the sphincter muscle, just the part where the faeces are liable to be stopped, and where an ulcer is most likely to extend through both the tunics.

I believe that the most common cause of abscess of this kind is, the lodgment of hard faeces in the bowels; by the straining that takes place to expel them the mucous membrane gets torn or abraded at one part, and then the passage of the faeces causes ulceration. Some time afterwards straining again occurs, and then the muscular tunic gives way, and the faeces escape into the cellular texture. Foreign bodies, however, in the rectum, sometimes cause abscesses. I mentioned two cases in the last lecture, but I shall mention them again. I mentioned them because they particularly appertained to the subject we were then discussing. I was called in by a gentleman who complained of great irritation about the rectum. I thought that he laboured under internal piles, but the next day he complained still more, and on examination of the rectum I found a hard substance sticking in the membrane. It was a piece of apple-core which he had swallowed the day before, and if it had not been extracted it would have occasioned ulceration, some of the faeces would have been pressed through the opening, and in all probability the apple-core would have been found in the cavity of the abscess. I was sent for to see another gentleman who was exceedingly ill with a large abscess in front of the anus. He had a brown or rather a black tongue, and bad typhoid symptoms. I opened the abscess freely, let out a quantity of putrid offensive matter, and, on introducing my finger into the abscess, I found a long fish-bone sticking across, with one end in the gut and the other in the abscess. He had swallowed the bone, it had stuck in the bowel, and a little of the faeces escaping by the side made a putrid abscess. Patients with disease of the liver, disease of the lungs, and in certain states of ill-health, are specially liable to abscess and fistula of the rectum. The reason is this: persons thus affected are peculiarly liable to ulcer of the mucous membrane; one of the mucous glandules is attacked, and

being very thin it gives way under the straining that takes place to expel the faeces, and faeces escape through the opening.

The first formation of an abscess about the rectum is not in general attended with very urgent symptoms. The patient has a sense of bearing down, a fulness and weight; he thinks that he has got piles, he puts his hand by the side of the anus, and finds a little hardness. After a time it increases, the parts become tender; there is pain when he passes his evacuations; perhaps some difficulty in passing them; by and by the pain becomes still greater, the skin inflames, the abscess, if left to itself, bursts, and a quantity of matter is discharged, which matter is almost invariably offensive, dark-coloured, and putrid. The disease sometimes forms so insidiously that the patient is not cognizant of it till the abscess has burst. Twenty years ago a physician in large practice in London felt very ill, languid, listless, unfit for business; and in the middle of the day, in consequence of headache and an incapability of exertion, wanted to go home and lie down for an hour before he could finish seeing his patients. One afternoon, intending to walk home, he had sent away his carriage. He found something give way, burst into his small-clothes, and on his return he found that it was a putrid abscess—a fistula. He went through an operation for it, and got well.

While these abscesses are forming there is sometimes little or no constitutional disturbance; but in other instances there is a great deal of it, and I believe that it depends chiefly on the quality of the pus, and that, again, on the size of the opening. If the opening be pretty large, and a considerable quantity of feculent matter escapes, the pus is then of a very putrid quality, and the more putrid its character the more offensive it is to the smell, and the more poisonous it is to the patient's system; for as it is more offensive to the smell so it is more loaded with sulphuretted hydrogen. Such a collection of putrid matter sometimes produces very urgent symptoms. I was sent for to see an elderly gentleman in the neighbourhood of London with the late Dr. Blickham. I will not say that on my arrival the patient was in *articulo mortis*, but he looked as if he had not long to live—I should say hardly twenty-four hours. On inquiring into the history of the case I ascertained that he had a fistula by the side of the rectum. He had suffered under it for many years; for being afraid of an operation he had let it go on. The external orifice occasionally closed for a time, but in a few days it opened again, and gave exit to the matter. Two or three months, however, prior to the time of which I am speaking, the outer orifice had closed, and there had been no discharge, and at first no inconvenience had been felt. By and by there was a sense of pressure, a bearing down of the rectum, and the patient became very much out of health. At last typhoid symptoms supervened, and he appeared, as I have said, almost dying. I examined the parts externally, and saw that the orifice of the fistula had cicatrised. I then introduced my finger into the gut above the sphincter muscle, and I could feel an immense tumour on one side, which was evidently a large collection of matter. With the forefinger of one hand in the rectum, with the other I ran in a lancet up to the point where the matter was collected. Not only the shoulders but the whole blade of the lancet was buried before matter escaped, and then there was a little putrid discharge. With a probe-pointed bistoury I dilated the opening, and there came away a pint of such putrid matter that the whole house was poisoned by it; it could be smelt

almost as bad as if a nightman had emptied his cart into it. The patient was better directly; though the incision was large there was no bleeding, and he recovered without a bad symptom. This circumstance took place many years ago, and he died lately of another complaint.

I have stated that the inner orifice of the abscess is always just above the sphincter muscle, and it may be that the abscess extends no higher than this. But in a great number of cases it does extend higher up—sometimes one inch, sometimes two; nay, I have sometimes found a probe pass four or five inches up the pelvis into a large cavity beside the rectum. These are cases of some interest, respecting which I shall have to speak to you again presently.

The external orifice of the abscess is generally in the skin, a little distance from the anus. Sometimes it seems to pass through the substance of the sphincter muscle, and on other occasions it opens externally to it. The abscess may burrow, and may be two or three inches away from the anus.

In some cases there is no external opening at all, and that may happen in two ways. I saw a gentleman who had an ulcer at the posterior part of the rectum as broad as a fourpenny piece. Some time afterwards I saw him again, and there was then a considerable discharge from the rectum, but no external opening. I introduced my finger into the rectum, and found that this broad ulcer had made a large cavity, in which matter was lodged, by the rectum. The sinus was so large that the matter had found its way out by the gut, and therefore did not burrow so as to make an external opening. But in other cases there is no external, while there are two internal openings, and they are found in the following manner:—There is a small opening through which the pus and faeces were originally infiltrated into the cellular membrane, and then the matter having collected near the gut, bursts into it, and makes a free opening in the neighbourhood of the first lesion. On examining the patient you find a discharge of pus from the inside of the rectum, and on introducing the finger you find distinctly the opening through which the abscess has burst into the rectum. This is what is commonly called blind fistula. The discharge in these cases is seldom quite constant; for the opening made by the bursting of the abscess into the rectum is not so large but what it sometimes contracts, and there not being a free discharge the matter collects, and you may feel it through the skin near the anus. This is important with regard to the treatment, as I shall explain hereafter. At other times the orifice allows the matter to escape by the rectum, and then the external tumour disappears.

In some cases there is a simple abscess and a simple sinus; but in other instances the disease is very complicated. The matter does not easily get to the surface, and it burrows in different directions; there is a sinus in this direction, and a sinus in that; sometimes it extends even to the middle of the nates, and there may be a sinus on both sides of the rectum. In these cases, where there are several sinuses, and where the disease is rendered complicated from the burrowing of the matter, it sometimes happens that there are two internal openings; but in general, however complicated the case may be, there is only one internal opening, and that communicates directly with one sinus, and indirectly with another. It is of great consequence to bear this in mind as connected with the surgical treatment. Where there are several sinuses, burrowing in different directions, the patient always experiences some degree of inconvenience. The matter lodges in one place, not in another, but

wherever it lodges it occasions pain, there is an attack of shivering, and then the matter escapes. It then lodges in another place, there is another attack of shivering, and in these complicated cases the patient is continually suffering local pain and tenderness, and these are combined with constitutional disturbance.

I now come to consider the treatment of these cases. Why is it that the abscess does not heal? It may, as I supposed formerly, partly arise from the unfavourable locality for healing, in consequence of the muscular fibres of the parts being always in motion. The levator muscle and the sphincter ani are constantly drawing the parts asunder, so that they are not allowed to contract, but that is not a sufficient explanation. There is an internal opening to the abscess, and now and then a little bit of faeces or mucus will become infiltrated, and get into the cavity. That which produced the abscess originally is going on still. If you could get the inner orifice to close, the patient would soon recover. This does sometimes take place. I saw a patient who had an abscess by the side of the rectum, and to whom I recommended an operation, but for some reason or other he wished to put it off. He went about for a considerable time with this abscess, and when I saw him again the abscess was closed, and had been closed so long, and on a careful examination the parts seemed so sound, that I had no doubt that the inner orifice had healed spontaneously; the escape of feculent matter was thereby prevented, and all the parts granulated and contracted like an abscess elsewhere. The medicine which we now call *consec. piperis nigri* was originally a quack medicine known by the name of Ward's paste. It is composed chiefly of black pepper and elecampane, and it had the reputation of curing fistula. I believe that it sometimes did so. It is very useful in the case of piles, and where there is an ulcer of the rectum unconnected with fistula. The black pepper mixes with the faeces, it passes down the canal, and becomes a stimulant to the mucous membrane. In this point of view it is useful to persons that suffer from disease of the mucous membrane after dysentery, or who have disease of the rectum. As it will cure piles and an ulcer of the rectum, so no doubt it will sometimes cure fistula. If the little ulcerated opening can be made to contract and cicatrize there is no reason why the external abscess should not heal. But you cannot depend on such a mode of treatment as this; it may or it may not happen to cure the patient, and for one instance in which it effects a cure it fails a great number of times. The disease, however, may generally be cured by a very simple operation, and in speaking of the operation we will take the simplest case first. We will assume that there is a fistula just by the side of the sphincter muscle and only one sinus. The first thing to be done is to find the inner opening. I do not say that you will always succeed in finding it—certainly not the first time, but you will rarely fail if you look for it in the right place. Formerly, I often failed, and for this reason,—I did not know where to look for it. I used to think that it was to be found in the upper part of the sinus, but it is never found there if the sinus runs high up. You must search for it immediately above the sphincter muscle. Another circumstance that makes it difficult to find is this:—The common probe being quite round turns round in the hand; you want a probe of a much broader kind, so that the least motion of the hand turns the point another way. For this operation I use the probe I now show you, made by Philip and Wicker, in St. James's street. First, it has a flat handle, and that gives you a perfect com-

mand of the instrument; secondly, at the extremity it is like a common probe; but you must have probes of different sizes. There is a groove, so that it is both a probe and a director at the same time, and being made of silver it is perfectly pliable.

Now, to find the inner opening place the patient over a table to the light, with an assistant to hold the legs. You introduce the fourth finger of the right hand into the rectum, remembering that the opening is close to the sphincter muscle. You will feel with the finger some little irregularity, and that is where the opening is probably situated. You are then to introduce this probe into the external opening with the assistance of the finger in the rectum, using no force, and by a careful manipulation feeling first in one direction, and then in another, at last it will almost alone pass through into the rectum. It must be done gently, and a little practice will enable you to find the inner opening. You ascertain when it has passed through the opening by its coming in contact with the finger. If you do not find the opening the first day put off the operation to another day. Occasionally I have tried two or three times before I could discover the opening, but generally, if you have probes of different sizes, it is easily found. Sometimes the opening is very small, and therefore requires a small probe. When you have found the inner opening, and the probe is in contact with your finger, you bend the end, and bring it out at the anus. Thus, the part towards the handle is seen projecting from the outer opening, and the other part from the anus, while the parts which are to be divided lie upon the groove of the director. I generally divide the fistula with a pair of curved knife-edged scissors, for they cut better than a bistoury. A bistoury tears, and you may cut your own finger if you use the sharp edge. Introduce the scissors along the groove of the director, and divide the parts that lie between the inner and the outer orifice. There is scarcely anything to be divided—not above an inch or an inch and quarter, but you divide the greater part of the sphincter muscle.

Having performed this operation, all you have to do is, to prevent the cut edges growing together. You have made it into a sore, some of the faeces go into the sore, but they do not lie and lodge there, and there is nothing to prevent this fistula, which is now made into an open sore, granulating and healing. All you have to do is to dress the parts very lightly between the cut edges to prevent them growing together, and that must be continued till the cut edges are skinned over. You may then leave the parts alone, and the healing process will go on.

But suppose that the fistula extends high up by the side of the rectum, above the opening, and this fistula is burrowing, what is then to be done? I used to imagine formerly that it was necessary to lay open the whole sinus into the rectum, but it is a frightful operation to lay open so long a sinus. You do not know what vessels you divide. There is seldom much bleeding in dividing the parts, between the inner and the outer opening, but if there be much the pressure of the finger and a bit of lint stops it directly. I remember a case where I divided a fistula some way up by the side of the gut, and the whole canal was filled with blood. It is true the bleeding stopped, and the patient got well, but still he might have died from haemorrhage. The bleeding goes on insidiously; you do not know how to stop it; it is internal, you cannot take up the vessels, and you cannot make pressure in any efficient manner. But I am now satisfied, and have been for a long time, that the division of a fistula which extends above the inner orifice is quite an un-

necessary proceeding. Upwards of twenty years ago, when I was first getting into practice, I had a patient with a fistula, which I divided, or, at least, thought I had done it. But one day, when examining it with a probe, I found a sinus running up by the side of the gut for several inches. It seemed as if one side of the rectum was completely dissected from the neighbouring parts, but there was a good opening at the lower part where I had divided the fistula. Not knowing what to do with the case I called in the late Mr. Cline, and observed to him that if I divided it the whole length the patient might die from loss of blood. He said, "You are quite right, but more than that I do not think it is necessary, I would leave it alone." There was a free opening below; the faeces could not escape so easily now, and get into the cavity above. I adopted his advice, and the patient got well without any trouble. I have since seen other cases of the same kind. Where there has been a large sinus, connected with a fistula, I have laid open the parts between the inner and the outer orifice,—done nothing more,—and the patient has got well. If a very long sinus, and a very large cavity, heal up without being laid open, *à fortiori*, if there be a small sinus, and a small cavity, that will heal up to.

In the next lecture I shall call attention to the treatment of more complicated cases.—*London Lancet.*

BIBLIOGRAPHICAL NOTICES.

A Practical Treatise on Midwifery: Exhibiting the present advanced State of the Science. By F. J. MOREAU, Officer of the Legion of Honour and of the Order of Leopold; Professor of Midwifery and the diseases of women and children in the Faculty of Medicine of Paris; Physician to the Lying-in Hospital of Paris; Consulting Surgeon to the King, &c. &c.

Translated from the French, by THOMAS FORREST BETTON, M. D., and Edited by PAUL B. GODDARD, A. M., M. D., Lecturer on Anatomy and Demonstrator in the University of Pennsylvania, &c. &c. With Eighty plates, comprising numerous separate illustrations. 4to, pp. 235. Philadelphia, Carey and Hart, for G. N. Loomis, 1844.

The first thing that takes our attention on looking at this valuable publication, is its admirable mechanical execution. The text is beautifully printed on fine white paper, and the illustrations are deserving of all praise. When we look back a very few years, and contrast the labours of our artists then with such specimens as the present, we are astonished at the great improvement which has been achieved in so brief a space of time. For the lithographed plates in the volume before us, we are, we believe, altogether indebted to Philadelphia artists, and the liberality of the very respectable publishers of the work.

The profession in this country are under great obligations to the Translator and Editor for enabling them to read the work of M. Moreau in their own language; for notwithstanding we have so many excellent treatises on the same subject, some of them, too, amply illustrated, still there is always room for one like the present. The author is not a man of yesterday,—no stripling,—but one of large experience and deep reflection,—long one of the brightest ornaments of the profession in the French Metropolis. We find in his work no silly affectation of

originality, but a frank avowal of the various authorities from whom he derives important facts and conclusions. In the bibliographical part,—which, although less copious than in several more recent productions, especially English and German, exhibits nevertheless considerable research,—the author acknowledges the assistance of the accomplished Brierre de Boismont.

The text treats of the usual subjects embraced in works on Midwifery, commencing with an account of the anatomical structure and peculiarities of the female pelvis and organs of generation, and their abnormal deviations; their functions in health, and the interruption of these by disease, together with the treatment to be pursued. Next comes conception, with an account of the ovum, and the signs of pregnancy. On the latter subject, although the symptoms are treated in detail, some of the indications pointed out by modern observation are not included. The principal part of the work, however, is devoted to the consideration of labour: commencing with "*natural labours*," or such as terminate in a reasonable time without assistance, and extending through all the complications and difficulties that arise. The whole are divided into *Classes, Orders, Genera, Species, and Varieties*, constituting the most artificial, complex, and difficult scheme for a young beginner, that we have met with in any late work on the subject. We regret this exceedingly; for however ingenious such elaborate classifications, with their divisions and subdivisions, may appear to authors, students rarely comprehend them, and practitioners never heed them in their daily pursuits. Some such arrangement is proper and necessary, but the simpler the classification and the fewer the subdivisions, so that all essential points of practice are embraced, the more likely is the subject to be investigated and understood by the student, and all beyond that, only perplexes and disgusts him. The practice inculcated by Professor Moreau, is on every point, so far as we have observed, judicious, and in many instances, illustrated by the narration of cases so apposite and so clearly and concisely told, that the dullest intellect can hardly misapprehend or forget what the author aims to inculcate.

The work of Professor Moreau is a treasure of obstetrical science and practice, and the American Edition of it, an elegant specimen of the arts.

On Superstitions connected with the history and practice of Medicine and Surgery. By THOMAS JOSEPH PETTIGREW, F. R. S., F. S. A., Doctor of Philosophy of the University of Göttingen, Surgeon to H. R. H., the Duchess of Kent, &c. &c. 12mo., pp. 213. Philadelphia, Ed. Barrington and Geo. D. Haswell, 1844.

This is a reprint of the London Edition, published last year. It is not only a neat little volume, well got up, but a most amusing, and in some respects, instructive one, which will well repay a perusal. It exhibits a sorry picture of the craft and weakness of the human mind, it is true; nevertheless, by the contrast which it affords when compared with the fruits of science and philosophy at the present day, we are enabled to form a better conception of the mighty powers with which the human intellect is endowed. At any rate, from the follies of the past we may derive wisdom for the future, and there is much in the volume before us that may be profitably used for this purpose.

Notes on Ovariectomy. By FLEETWOOD CHURCHILL, M. D., M. R. I. A., Hon. Fellow of the Philadelphia Medical Society; Physician to the Western Lying-in-Hospital and Dispensary; and Lecturer on Midwifery, &c., at the Richmond School of Medicine." (Read before the Dublin Obstetrical Society.)

(For this and two other interesting communications, which we shall notice hereafter, we are indebted to the kindness of Dr. Churchill, and beg he will accept our thanks for the same.)

In this paper we have, condensed into a small compass, the whole of our experience in regard to this fearful operation. After noticing "one or two points in the pathology and history of the disease for which ovariectomy is proposed as a remedy," the author gives a brief account of the cases operated on, the names of the operators, the time when the operation was performed, and the results; and for more convenient reference, the whole is then thrown into tables.

The following is the concluding part of this able paper:

Let us now attempt a little closer analysis of these cases. It will be remembered that the question at present is not whether each operation was justifiable or suitable, but merely as to the results of the operation under given circumstances.

1. The entire number of cases—whether dropsy, or scirrhus of the ovary, uterine disease, or simulated tumours—amount to sixty-six: of these forty-two recovered, and twenty-four died, or about 1 in 2 $\frac{1}{2}$.

Of the forty-nine cases in which the ovary was extirpated, sixteen died, or 1 in 3 1-16ths. Of the nine cases in which the operation could not be completed, four died, or 1 in 2 $\frac{1}{2}$; and of the eight cases where the operation was unnecessary, four died, or 1 in 2.

2. It is not quite so easy to give the comparative mortality of the long and short incision, because the definition of each is scarcely settled. Taking the length of the wound as our guide, without reference to the tapping of the tumour before extraction, we will include all cases under the term "minor operation," where the incision did not exceed four inches; and under the term "major operation," where it exceeded that.

Of the true ovarian cases in table 1, there are fourteen cases of the short operation, of these thirteen recovered, and two died; and thirty-four cases of the long operation, of whom twenty-one recovered, and thirteen died, or 1 in 2 8-13ths. In the second and third table there are fifteen cases of the long operation, of whom seven died, or 1 in 2 1-7th. Of the forty-nine cases of the long operation twenty died, or 1 in 2 $\frac{1}{2}$. At the same time it must be observed that in the cases of the short operation there are much less irritation and injury owing to the absence of adhesions; and in some cases the short operation would have been perfectly useless, so that if any attempt were to be made, it must be by the long incision, with all its risks. The comparison therefore is not quite fair.

3. Age does not appear to have had much influence upon recovery or death, for the ages mentioned in six of the fatal ovarian cases were 23, 25, 40, 40, 47, and 59; whilst those of the successful ones range between 20 and 60.

The same may be said, as far as the information extends, of the married or single condition of the patients.

4. At first sight one would expect a considerable variation in the result of cases in which there were

adhesions from those in which there were none, because of the violence necessary; and this seems to be confirmed by the cases of Chrysmer and others, where the patients died of gangrene of the peritoneum; yet of seventeen cases in which the adhesions were found, and in some very extensive, eleven recovered, and six died. This, however, shows the great disadvantage of adhesions, and there are certain cases, one of which we have just seen, in which these were so extensive that removal of the tumour would have been impossible.

5. Certain of the operations (Chrysmer, Clay, &c.) were performed upon women labouring under other organic diseases, or suffering from great constitutional exhaustion, and these cases proved fatal.

6. The operation was several times frustrated by the excessive vascularity of the tumour, or its firm attachment to the pelvis, and though several of them (four out of eight) recovered, yet these are additional reasons for serious investigation.

7. It is further shown by table 3, that the operation was performed when no tumour at all existed—when the tumour was uterine, or growing from the pelvis, or an hydatid. At first sight it might be supposed that such errors of diagnosis were the result of carelessness, and that the first could scarcely occur. And yet Mr. Lizars is a surgeon of no mean experience; and M. Dolhoff had his patient in hospital under his observation for a year or so. Very lately I was consulted for a supposed ovarian tumour, and upon examination there was a distinctly shaped abdominal tumefaction, which had all the feel of a uterine or ovarian tumour, and yet upon calling off the patient's attention, and setting the abdominal muscles into action, it entirely vanished.

It may be worth while now to look a little closer at the *diagnosis* of these tumours.

1. The abdominal muscles appear to acquire the power of involuntarily assuming the form and appearance, and of communicating the sensation of a tumour. In some cases it seems as though the result of the form given to them by a former pregnancy. Against this deception we can in a great measure guard ourselves, by prolonging our abdominal manipulation, and calling the muscles into action by leading the patient to converse. Percussion will also aid us in coming to a right conclusion, and if we make an examination per vaginam and per rectum, there will be but little doubt remaining. And I would observe that an examination per rectum is most valuable in all cases of real or supposed ovarian disease.

2. In the majority of cases the continuity of the tumour, ascertained by the perception with a finger on the os uteri of a shock impressed upon the abdomen, is nearly decisive of a tumour being uterine, and the very feeble or absent impression of such shock, of its being ovarian. The exceptions are mainly those cases where adhesions have taken place, uniting the pelvic viscera closely together. Dr. Simpson of Edinburgh has recently proposed the use of a bougie for this purpose. It is to be introduced into the uterus, and then, he states, that by turning it one way, and pressing the tumour the other, it is quite possible to establish a distinction between the uterus and ovary in cases of ovarian disease. Or it might be possible that the direction taken by the bougie would establish the same fact.

Again, a careful examination per rectum and per vaginam will very often, even where the tumour is adherent, prove that there are two tumours, and their different density, or the comparative vividness of shocks communicated from the abdominal tumour,

may justify the inference that one is the uterus and the other the ovary.

Lastly, the history of the disease may throw some light upon its nature. Uterine tumours are generally of slower growth, of smaller size, more dense to the touch, seldom attacked by inflammation, and rarely painful; and although none of these circumstances are conclusive alone, they may be very decisive in conjunction with other signs.

3. It may not be very difficult to come to a conclusion as to the existence of adhesions, though far from easy to estimate their extent. The mobility of the tumour, if it do not fill the entire abdomen, will generally decide the question; but when the disease attains an enormous volume, we can do little more than form a conjecture. There is a sort of rolling feel when a tolerably free ovarian tumour is moved, and a crepitus when adhesion has occurred, which is not easily mistaken; and a change of posture may afford additional information.

4. It is, of course, almost impossible to estimate the vascularity of an abdominal tumour. Occasionally we may distinguish with the finger the pulsation of an artery, and more than once I have ascertained the fact with the stethoscope. A careful examination should always be made with this instrument.

These hints may show at least the obscurity of the means of diagnosis, and perhaps aid a little in dispelling some of that obscurity. At all events it is certain that difficulty and doubt exist, or such mistakes would not have happened in the hands of careful men; and as these errors may be repeated, I would earnestly advise that when, on opening the abdomen, the tumour is found to be uterine, no attempt be made to remove it. The patient has a far better chance of recovery if the disease be untouched, and it is unlikely that any evil consequences will result from the tumour itself. It is a sad reproach that a patient should die, not of the operation, but in consequence of attempting that which was not originally contemplated.

Conclusion.—Even after the details I have given, it is very difficult to come to a definite and perfectly satisfactory conclusion, because, 1. we have not sufficiently accurate data to estimate the progress of the disease unaided by surgery. 2. The table quoted from Mr. Southam is clearly too limited to afford a fair average of the results of tapping, and it is not easy to obtain sufficient facts to enlarge it. 3. The cases in which ovariotomy has been performed are of such a mixed character, that it is impossible to select with fairness those cases in which the operation was demanded for the relief of urgent suffering, and suitable to the nature of the disease, without the appearance of partiality. And 4, from the obscurity of the diagnosis, it is too much, perhaps, to expect that our practice in future will be free from those drawbacks on the operation.

But bearing in mind these difficulties, and making allowance for those drawbacks, I think we may conclude that there are cases in which the operation would be justifiable; and on these grounds,—we find the general opinion is against the curability of the disease by medical means;—that after a time the patient will die from local disease or accident, or constitutional disturbance, and that meantime she suffers more or less inconvenience;—that tapping in almost all cases affords but temporary relief;—and that, as far as the limited statistics we have adduced are admissible as evidence, it is attended with great danger; i. e. 1 in 5 died of the first operation, and of twenty patients, fourteen (more than two-thirds) died

within nine months of the first tapping; whilst of the entire number of those who underwent the operation of ovariotomy, about one-half have absolutely recovered so far.

We may add, that of those who died, some were in an unfavourable condition for any great operation, and many had no other hope of relief.

2. If we reject those cases in which the operation could not be completed—those in which it was unnecessary, and those when the patient laboured under organic disease, or a debilitated and broken constitution, the mortality is twelve in forty-two, or 1 in 3½. Even making allowance for the difficulty of diagnosis, it does appear to us that in future sufficient judgment may be exercised to reduce the proportion to something near this.

3. Again, if the operation were confined to cases of unilocular cysts without adhesions, or even to cases requiring the major operation where no adhesions exist, the results, according to our statistics, would be more favourable. At present it would seem desirable, if possible, to limit the operation to these cases.

4. Let it be observed, that so far we have canvassed the merits of the operation *on the recorded results*, not on the propriety or impropriety of it in any or all of the cases related; but it would be impossible to shut our eyes to the fact, that it has been sometimes performed without a due regard to the condition of the patient—to the necessity of an operation at all—or to the one in question being exactly adapted for the purpose.

To justify the operation in an individual case, the patient should be so far inconvenienced by the disease as to require surgical relief of some kind; and yet, on the other hand, she ought not to be in a condition which would prohibit other great surgical operations. In such cases the alternative is tapping or extirpation, and our judgment should be formed upon a careful estimate of the results of each.

Again, it is clear that no operation of this magnitude should be attempted when there is coincident organic disease of a serious character in other organs; nor have we sufficient evidence to justify an extension of the operation to other diseases than those of the ovaries.

5. As to the mode of operating, it appears to me, that it is better to commence with the small incision, and, if necessary, afterwards enlarge it. The great advantage of this plan appears to be, that after making the incision (in some sort an exploratory one,) if the sac, after being emptied, can be drawn out, we escape with the slighter risk; if there be obstacles, owing to solid matter, it can be enlarged without difficulty; and if these obstacles be such as to deter us from completing the operation, we can recede with much less danger to the patient; and this I think of vast importance, considering the present uncertainty of our diagnosis.

I have thus endeavoured to lay before the Society such information as I have been able to obtain concerning this important operation, without appearing as its advocate or its opponent, beyond what the statistical results will justify. These results are, I think, neither so favourable as some of its friends have represented, nor so discouraging as its opponents have asserted."

At a meeting of the *Royal Medical and Chirurgical Society of London*, held on the 25th of June last, Mr. Benjamin Phillips read a paper on this subject, based upon an examination of sixty-nine cases in which the operation was performed. "In fifty cases, a tumour

was extracted; in fourteen cases, adhesions, or other circumstances, prevented its removal; and in five instances, no tumour was found. Of the cases in which the operation was completed, the tumour being extracted, thirty terminated favorably, and the patients recovered; in twenty instances, the termination was unfavorable, and the patients died. Of five cases in which no tumour was discovered, all recovered. Of the fourteen in which adhesions, or other circumstances, prevented the extraction of the tumour, eight recovered, and six died." It will thus be seen that Dr. Churchill and Mr. Phillips agree very nearly in their account's of the statistics of this operation: there is also a very general concurrence between them on all the important points presented in the consideration of the subject of ovariotomy.

In the opinion of Mr. Phillips, "the preponderance of success is in favour of what is termed the minor operation, (as compared with the major) that is to say, an operation in which the incision is as small as is consistent with the easy removal of an *emptied* cyst, provided it be large enough for the convenient application of the ligature around the pedicle.

In the last number of the American Journal of the Medical Sciences, we have an account of a case operated on by Professor W. L. Atlee, of Lancaster, on the 29th of March last. The patient was 61 years old on the 26th of the preceding November—the incision extended from immediately below the umbilicus, in a straight line, to within one inch of the symphysis pubis. The uterus and right ovary were sound; the left, with its corresponding fallopian tube, was involved in the tumour which was removed. "The tumour, immediately after the operation, weighed ten and a quarter pounds; its greatest circumference being two feet nine inches; its smallest, two feet." The operation was performed with skill and tenderness, and the patient bore it well, but on the third of April (four days after the operation) she died, labouring under peritonitis. After death, "a globular cyst, about the size of an orange, was lifted up from the deepest part of the pelvis, and was found to be pendulous from the right ovary."

Cyclopaedia of Practical Medicine.

Parts X. and XI. of this valuable work have appeared with their accustomed regularity. Part XII. will complete one half of the extensive undertaking.

THE MEDICAL EXAMINER.

PHILADELPHIA, AUG. 24, 1844.

A subscriber in the West has kindly sent us the "Morning Courier" (a *political newspaper*, published at Louisville, Kentucky) of the 16th, 17th, and 18th ult., containing a long and scurrilous attack on us for some Editorial remarks on the subject of Medical teaching, in a former number of the Examiner. Although the writer had not honor and self-respect enough to restrain him from writing and publishing such a tirade of vulgar personalities, we are glad to find that he had sufficient to make him ashamed to put his name to it.

SYDENHAM SOCIETY.

We learn, that two of the valuable works published by the Sydenham Society for 1843, will soon be in the hands of their subscribers in this country; and that the third work is probably ready by this time. Dr. Dunglison has not yet received the annual report, but in a letter to him from Dr. Bennett, dated London, July 12, 1844, it is stated, that according to it the subscription for 1844 is now due. "We shall not, of course," says Dr. Bennett, "enforce the fine, &c. of this rule on you, on the other side of the water. At the same time, please remember, that unless the subscriptions for the second year are paid soon, there will be a chance of our not being able to supply the unpaid with books. You will at once see that unless we fix some time for payment, we cannot tell how many copies to print nor what funds we have to spend." "We ought not," he adds, "to complain of the slight difference in the subscription arising from the relation of the five dollar note to our £1 1s.; your 80 dollars will yield the society £15 9s. 3d. for the 16 subscriptions, after all expenses of remittance, &c. are discharged. This is quite as near as we can expect." It will be thus seen, that the subscribers on this side the Atlantic receive the books from the society in London at a less price than the English members.

The number of subscribers for 1843 has been so great, that the society are only able to furnish copies of the works published for that year to the twelve names first handed in by Dr. Dunglison. "You will see," says Dr. Bennett in his letter to that gentleman, "by the report, p. 23, how we were situated at the time of the last annual meeting in May, as regards the number of books on hand. The fact is, I have not, by a great many, sufficient to supply all who wish to join the society for the first year; and I am sorry to say, that I have not enough to supply all the persons whose names you have sent me. I have, however, sent you 12 copies of each of the works already issued, for the 12 names first in order in the lists sent in by you. The others we shall enter as subscribers for the current year, that is 1844-5. There will be a third volume for the 12 first year's subscribers, which, I hope will be ready to go by the end of the month. It is now in the binder's hands. A first volume for the current year will be out in about two months, in all probability." As soon as the report arrives we shall notice it; and a copy of it will doubtless be furnished by the Honorary Local Secretary to each of the subscribers.

It may be proper to add, for the information of the parties concerned, that the twelve subscribers referred to by Dr. Bennett sent in their names to Dr. Dunglison prior to the middle of June. Those who subscribed afterwards belong to the subscription year of 1844-5.

When the books arrive, due notice will be given to the subscribers.

It is somewhat strange to us, that there should be hesitation on the part of any one to subscribe to this important undertaking. In no other manner can the same amount of valuable matter be obtained so reasonably. Five dollars per annum procures from the society, at least three works that could not be obtained in any other manner; and hence it is not astonishing, that the influx of British members for 1843 has been so great as to render it impracticable for the society to supply them all.

DISEASES OF THE MISSISSIPPI VALLEY.

From various sources, but more especially from a note by Professor Drake, published in the *New Orleans Medical Journal*, we are informed that that distinguished gentleman is engaged in collecting materials for "a history of the prevalent maladies of the Mississippi Valley." We regard this as a highly important announcement to the profession. Nothing could be more opportune than such a work from such a source. No man is more capable of preparing a faithful account of the diseases of that section of the country than Dr. Drake, and this we doubt not is the opinion of the profession.—For ourselves, we shall look for it with particular interest. We have so many contradictory accounts from essayists,—sometimes perhaps from want of knowledge to appreciate what they see, but more generally, it is probable, because of the modifications which occur in different years and seasons of the year,—that we are at a loss as to the degree of credit that should be attached to any thing we meet with on the subject.

When the book of Prof. Drake appears, we shall have a standard—something that will enable us to appreciate the extravagant and nonsensical prating about the giant diseases of the West and South of which we have heard so much—often from men who, very unlike Professor Drake, possess neither the capacity, the habits, nor the opportunities for observation, which are necessary to command the confidence of the profession. In short, we shall be able to judge whether diseases and their treatment, which are every where else amenable to the well established laws of pathology and therapeutics, are in the Valley of the Mississippi an exception.

THE BOSTON MEDICAL AND SURGICAL JOURNAL.

On the 7th of the present month, this popular periodical entered upon its *thirty-first* volume. In announcing the fact, the Editor, in appropriate and feeling language, adverts to the toil and solicitude which the Journal has cost him in the years that have past, and gratefully acknowledges the "untiring kindness, assistance and patronage" by which he has been encouraged and sustained.

"Journals of medicine, (he remarks) like other enterprises, have greatly increased, as the natural result of the increased facilities and resources of a great and prosperous nation. Some, indeed, have only breathed to die; and others, after having maintained for a while a sickly existence, were compelled to yield to the force of circumstances, and finally disappear. Ours is now the only one in the United States which is published weekly, having survived, unharmed, the rivalry of no less than three publications of the same class. It requires something more than a prospectus of operations, to maintain a medical journal. There is necessarily a fearful outlay of capital, quite discouraging at first; and when there is taken into account the great number of losses annually occurring, very few, it is presumed, would be willing to enter anew upon the business, after having had experience in permanently establishing one. Unlike other periodicals, its subscribers are of necessity only here and there one out of hundreds and thousands, and then they are spread so widely over the entire face of the Union, that collections are always difficult. Still, under all the aspects of the case, we have passed on till the commencement of this *thirty-first* volume. We hope for the continued good will, and the literary and scientific assistance of our brethren. With their continuance, and our own continued exertions, the Journal

will pursue its quiet way, without ostentation, or a presumptuous display unbecoming the legitimate object to which it is expressly devoted, or the character it has attained."

Our estimable brother need have no apprehensions for the future. His enterprise is no longer an experiment. The industry, talents, and imperturbable good nature which he has heretofore displayed, are a guaranty which will secure for him the continued support of an enlightened and generous profession.

WESTERN JOURNAL OF MEDICINE AND SURGERY.

Just as our present number was going to press, and after the greater part of the matter was in type, we received the August number of the respectable Journal above named, in which we find an article, referring to the disreputable publication alluded to in another column, that calls for a reply. Under the caption of "Medical Examiner and Western Medical Schools," the following remarks occur, written by one of the editors:—

"We must say that we consider the allusion to *Western Medical Schools* by the editor of the *Medical Examiner*, in the number of that paper for June 29th, an unfortunate one. We hope without intending it, he has made a charge against his brethren in this region which must give general and deep offence."

We are no admirer of obstinacy, nor of those who affect infallibility; nothing indeed affords us more pleasure, when properly called upon, than to explain or retract any thing that we may have said or done, calculated to give unprovoked offence. The remarks, above referred to, are not *discourteous* and they are not *anonymous*, and we have therefore no hesitation in making the proper reply. We say, then, with perfect frankness, that since the Editor thinks our remarks of the 29th of June are calculated to produce the impression, that we meant to charge either dishonor or incompetency on the *Western Medical Schools*, our remarks were "unfortunate." We had no such design. The Editors of the *New Orleans Medical Journal* asserted, in substance, the doctrine which we have understood to be perseveringly promulgated by *one* individual in the West for years past, that those who study their profession "in the capitals of Europe and the United States," are unprepared to practise medicine in the Valley of the Mississippi, until they have established for themselves "a new code of principles and practice." This doctrine we regarded, and still do regard, as degrading to the science. The *New Orleans Journal* furthermore asserts that "the Medical Profession has been for sometime gradually losing caste and respectability in the South—that unworthy and incompetent members are constantly gaining admission into the ranks—and that the charlatan and empiric annually find it less difficult to maintain a successful competition with the licensed practitioner." We mentioned the fact, that since the establishment of Medical Schools in the Valley of the Mississippi, comparatively few young men from that region seek instruction elsewhere, under the belief that there only can they learn the peculiar diseases of the South; and, consequently, we inferred that if the profession in that quarter was "gradually losing caste," the Medical "Schools in the Capitals of Europe and the United States," were certainly guiltless of contributing to the unfortunate result.—Our object was to protest against what we regarded

as false teaching, calculated to contract the views of ingenuous youth; but we had no intention whatever of casting any imputations of a dishonorable character upon the Western or any other Schools. In nearly all of them we have personal friends—men whom we know to be honorable, liberal-minded, and intelligent—and we know how to separate such from individuals of a different stamp. In conclusion, we have only to add our extreme regret that the able and respectable Editors of the *Western Journal of Medicine and Surgery* should have thought it necessary for them, *under any circumstances*, to admit to their pages language in relation to us which one of them confesses he "should avoid,"—such as he certainly never employs;—and that language, too, extracted from an anonymous contribution to a newspaper.

PHILADELPHIA DISPENSARY.

At a meeting of the Managers of this Institution on the 20th inst., Charles Huston, M. D., was elected one of the Physicians, in the place of William B. Page, M. D., resigned.

We have received the Annual Announcement of the Willoughby University of Lake Erie, for the course of lectures in the Medical Department for 1844-5.

The Professors are:

Amasa Trowbridge, M. D., Professor of Surgery.
George McCook, M. D., Adjunct Professor of Surgery.
Henry H. Childs, M. D., Professor of Obstetrics, &c.
James Quackenboss, M. D., Professor of Anatomy and Physiology.
Robert H. Paddock, M. D., Professor of Chemistry and Pharmacy, and Materia Medica.
John Butterfield, Professor of Theory and Practice, &c.
Isaac J. Allen M. D., Counsellor at Law, Professor of Medical Jurisprudence.

Professors Childs and Trowbridge are veteran practitioners, as well as teachers, whose reputation must prove advantageous to the school. "The College is located in the village of Willoughby, Lake County, nineteen miles east of Cleveland, and fourteen west of Fairport."

RECORD OF MEDICAL SCIENCE.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.

It is officially announced by the Royal College of Surgeons, that the following are the hospitals and schools of surgery and medicine in foreign countries, from which certificates of the professional education of candidates for the fellowship will be received by the college for the year commencing the 1st inst.

"The several hospitals and schools in the following cities, viz. Paris, Montpelier, Strasburg, Berlin, Vienna, Heidelberg, Bonn, Göttingen, Leyden, Pavia, New York and Philadelphia.

By order of the Council,
EDMUND BELFOUR, Secretary."

July 13, 1844.

London Lancet, Aug. 3, 1844.

TANNING A CHANCRE.

M. Ricord is unquestionably a man of crotchetts. His vagaries are so manifold that he is a sort of "Pacha of many tales." His last is to tan a chancre, and to make it drunk—why, Heaven only knows, unless it is for the sake of making blockheads gape, and

other people stare, a motive perfectly à la mode and French. But, for the process.

M. Ricord's favorite application is lint impregnated with aromatic wine. This is a decoction of sage, rosemary, thyme, hyssop, mint, &c. in eight times their weight of Burgundy wine. It destroys the contagious quality of the secretion from a chancre and tans the neighboring parts, rendering them less susceptible. M. Ricord has now and then found benefit from the addition of from one to six per cent. of tannin to the foregoing, to promote the latter purpose.—*Prov. Journ.*

What stuff is this! Tanning the skin around a chancre to prevent the spreading of infection! If it is received into the system, it is by the absorbents passing to the sore itself, and tanning the skin around cannot affect them. The spreading of the mere sore is prevented in one of two ways, or in both—by stimulating the part and exciting healthy action, or by acting on the system, and through it obtaining the same result. M. Ricord's wine and thyme, &c. are just a local stimulant and nothing else, and, no doubt, there are plenty as good or better—whilst the tanning is all a matter of moonshine. *Et voilà tout.*—*Med. Chir. Rev.*

CASE OF HÆMORRHAGE OF THE LIVER.

By J. ABERCROMBIE, M.D. of the Cape of Good Hope.

The patient was a lady, 35 years of age, who, during the last two months of her pregnancy, had suffered much from dyspepsia. On the 28th September, 1841, she was seized with severe pain in the epigastrium, a sense of distention, eructations, and nausea. Having on former occasions been relieved of (what she considered) a similar pain by pressure, she had recourse to it on this occasion, by bandaging the waist, and to such an extent, as to cause the author to fear mischief might be produced. Opium and ether were given, and in the evening she was quite relieved. On the following morning, however, labour came on; it was of a short duration; the placenta was readily expelled, and the uterus contracted well. Within an hour, however, symptoms of sinking appeared, leading the author to suspect uterine hæmorrhage, but on examination the uterus was found perfectly contracted, and the discharge outwardly very moderate. She complained of pain in the right hypochondrium, and right side of the neck. Opium and stimulants were freely given, and for a time she seemed to rally, but vomiting supervened; collapse of the system took place, and she died on the morning of the 1st of October. On examination after death, there was found on the anterior and inferior surfaces of the liver a large sac, which burst on attempting to remove the organ, and discharged about two pounds of blood, fluid and coagulated. It was found to have escaped from a branch of the vena porta, and the sac was formed by the peritoneum. The organ itself had throughout a mottled appearance, and was unusually soft. The uterus was in a perfectly sound state, as were all the other organs of the viscera, both of the pelvis and abdomen.—*London Med. Times.*

LEPRA VULGARIS.

Dr. J. C. Hall relates a case of long-continued lepra, attended with inflammatory symptoms and violent itching, in which, after premising venesection and the use of purgatives, he effected a cure by the cautious use of the liquor of the hydriodate of arsenic and mercury. He lays great stress upon the

propriety of not exhibiting the arsenical preparation, until the indications of inflammatory action have been previously removed.—*Ibid.*

ABSCESS OF THE HEART.

M. Gintrac has published in the *Journal de Medecine de Bourdeaux* the case of an old man, long subject to palpitation, with dyspnea, etc., and who was under his care for a few days. His respiration was short and uneasy, there was orthopnea, cough, and bloody expectoration. The heart's action was strong and irregular, and heard over a large surface:—no bruit could be distinguished. On dissection, from twelve to fifteen pounds of a thick reddish and yellow fluid, consisting of pus and bloody serum, were found in the pericardium, and there were distinct layers of pus on the anterior surface of the heart, especially on the left side, where a small ovoid opening was found in its substance. The lower part of the left ventricle was separated from the rest by a thick unorganized septum, and contained a thick purulent fluid, the color of the lees of wine. The muscular fibres in this part were pale and softened, and soaked in pus, which seemed to have passed between them from a fistulous opening in the anterior wall near the septum, communicating with that at the surface of the heart.—*Ibid.*

POISONING BY CORROSIVE SUBLIMATE.

Dr. Watson, of the Royal Infirmary, at Glasgow, records, in the *London and Edinburg Medical Journal*, a case of poisoning by corrosive sublimate, which occurred in his practice, the principal features of which were that, although the patient lived seven days after having swallowed the poison, no real salivation took place. The gums were only slightly swollen; there was no mercurial foetor; the teeth were firm; and the flow of saliva was confined to the first day after admission into the hospital, when it might be partly occasioned by nausea, but especially by the irritation of the fauces, and difficulty of swallowing. The effects of the poison were confined to the alimentary canal, or nearly so, but the whole track of the canal was not equally acted on: the oesophagus, the left half of the stomach, the lower part of the ileum, the colon, and especially the rectum, were chiefly affected; and those parts, although the seat of violent action, were free from abrasion. The urinary bladder, and the lining membrane of the larger bronchi, had also participated, although in a minor degree, in the general irritation of the mucous membrane. Chemical analysis did not detect any traces of the poison in the alimentary canal. The liver, in which Orfila has recently discovered indications of corrosive sublimate in cases where it has been administered internally, does not appear to have been examined chemically.—*Ibid.*

USE OF CHLORIDE OF SODIUM IN DISEASES OF THE EYE.

Dr. Tavignot (L'Experience) employs the chloride of sodium, as a topical application, with advantage, in the treatment of different forms of inflammation of the eye, and more particularly in ulcerations of the cornea, in the form of ointment or collyrium, and sometimes even in substance. He considers it to be more efficacious than nitrate of silver, and other substances which are commonly applied, in such cases, and less likely to produce permanent irritation, or to act as an escharotic. The ointment is prepared in the proportion of one to four drachms of common salt to the ounce of lard; the weakest pre-

paration being used at the commencement of the treatment, and the collyrium is made with from one to three drachms to the ounce of water. One drachm to the ounce will be sufficiently strong for ordinary cases.—*Ibid.*

POISONING BY SULPHATE OF IRON.

A case of considerable importance in a medico-legal point of view, is reported in the *London and Edinburg Medical Journal*, as having occurred to Dr. Christison. A child, four years of age, having died in circumstances which excited strong suspicions of poisoning, an investigation was made by the law authorities nearly four months afterwards. The symptoms presented by the child were violent vomiting and purging coming on after breakfast, followed by death in the afternoon of the same day. The suspected person was proved to have purchased both sulphate of copper and sulphate of iron not long before, and was seen by the other children to mix a blue liquid for drink after the symptoms began. Copper was naturally suspected, but there was not any found, either by the Messrs. Dewar, who conducted the first analysis, nor afterwards by Dr. Christison; but there was obtained a large quantity of iron, partly in the soluble condition, but chiefly in the form of a compound insoluble in water. This appeared to be in a great measure sulphuret of iron, formed by the decomposition of the sulphate, through means of the sulphuretted hydrogen and ammonia, disengaged during the decay of the body, for water which had acted on the contents and textures of the alimentary canal, presented evidence of a much larger quantity of sulphuric acid than would have arisen from the ordinary contents: and the whole course of the mucous coat from the mouth to the anus, was thickly lined with a layer of jet-black mucus. The tissues of the stomach presented everywhere the same color. Iron was also found largely in numerous brown stains on the child's clothes, and the apron worn by the person suspected to have administered the poison. Messrs. Dewar made some experiments with sulphate of iron, from which they came to the conclusion arrived at by Orfila and Smith, that two drachms retained in the stomach by a ligature on the oesophagus will cause death in a few hours. The process employed for detecting the iron, consisted in incinerating the contents and textures, acting on the residue with diluted nitric acid aided by heat, adding an excess of ammonia, and transmitting sulphuretted hydrogen. The ammonia separates a yellowish precipitate of sesqui-oxide of iron, and does not render the liquid blue, if there be not any copper. The sulphuretted hydrogen then produces black sulphuret of iron.—*Ibid.*

FLAYING CRITICISM.

We extract the following notice from the last number of the *Medico-Chirurgical Review*.

VIVISECTION.—LETTER TO THE EARL OF CAERNARVON. FROM RICHARD JAMESON, Esq.

It appears that Lord Caernarvon is President of the "Society for Preventing Cruelty to Animals," and, as such, has been holding forth against the high crimes and misdemeanors of the medical profession for torturing animals to death in their physiological experiments! A certain Rev. J. Styles has gained a prize of £100 for the best Essay on this Pseudo-philanthropy, and has informed the public—"that every surgeon's apprentice thinks himself entitled to find his way into the *arcana* of Nature by

scalping cats and rabbits *to see where their brains lie.*" This is not merely a "clerical error," as the lawyers say, but a clerical lie. Admitting, for the sake of argument, that the medical profession should exhibit, among its numerous ranks, an instance or two of such senseless cruelty, is that any reason for using the sweeping assertion that "*every surgeon's apprentice, &c. &c.*?" Does the ecclesiastical world never exhibit a black sheep?—If, because a Bishop was seen running down St. James's street with his "*lights*" about his heels, we were to assert that *every clergyman was a _____*, what would this mendacious John Styles say to the accusation?

The only apology that can be offered for this Doctor of Divinity is, that he is a credulous ass. Thus, to astonish the Gobe-Mouches among the auditors, he tells them that oxen are driven many days without food, with "*their hoofs worn off, and on bleeding stumps!*!" Why Baron Munchausen was nothing to this D. D.! Can he be so silly too as to suppose that a grazier or a butcher would starve his cattle for days together, and thus to reduce their weight and condition as to suffer a considerable loss in the sale? This sapient philosopher tells us that the Hippopotamus, whose side would resist a musket bullet, has recourse to phlebotomy, when sick, by running against the point of a reed!! By way of contrast to the surgeons' apprentices, he informs us that predaceous animals destroy their victims with the least possible amount of pain, and that it is usually in the night time, when they are asleep, that they pounce on their prey, murdering them before they have time to reflect on their own danger! What tender-hearted creatures these tigers, hyenas, cats, and owls are! It is not because they can surprize their prey more easily in the dark than in the light, that they prowl about after sunset, but entirely to save the deer, goats, mice, and sparrows, the pain of being slaughtered! See how the cat domesticated among our amiable tabbies, fondles and soothes its victim the mouse, before it gives the final coup de grace!

But look at MAN himself. Leaving aside the wars, murders and persecutions of all ages, see how many thousands of animals are annually slaughtered in the most cruel manner, by your nobility and gentry, while hunting the stag, the hare, &c. and that for mere sport, and without any regard to science or ultimate utility. The subject is extremely well handled by Mr. Jameson, and does great credit to his head and his heart. We strongly recommend its perusal.

Case of Acute Retinitis, caused by the use of the Microscope. By WILLIAM WHITE COOPER, Esq. Surgeon to the North London Ophthalmic Institution, &c.

The following case is considered interesting by the author, as offering a warning to those microscopical investigators who are in the habit of pursuing their researches with powerful instruments, and the aid of strong and concentrated light. Mr. G_____, a gentleman well known for his remarkable skill in minute and microscopical dissection, was engaged on Friday, the 29th of March last, dissecting the nerves of the human tongue, under a powerful microscope, and in a situation exposed to the full influence of the sun, which, although occasionally obscured, burst forth at times with great power. The nerves, having been cleanly dissected, were of a dazzling white, and, whilst he was intently regarding them through the microscope, the sun, which had previously been obscured, suddenly shone forth with all its brilliancy upon them. Acute pain was instantly felt in the eye,

pervading the whole globe, so severe as to induce Mr. G. to start back and utter an exclamation. He paused from work, but for some time was not able to see any thing with that eye, the spectrum of the sun continuing before it whether closed or open. In about twenty minutes, however, this, as well as the pain, had sufficiently subsided to enable him to resume the work with the other eye; but the injured organ was not free from uneasiness until the evening. The following day the eye was not painful, and he inadvertently used it to complete his dissection, when the very same occurrence took place as on the previous day—the reflected rays of the sun being thrown powerfully on the retina. This time the shock was excessive; great and deeply-seated pain pervading the whole globe, with much intolerance of light, immediately set in, and the spectrum of the sun was most distressing. He remained in acute suffering all the evening and the following night; and, on the next day (Sunday), it continued to increase, with a sensation of fulness and tenderness of the globe, and extreme intolerance of light. Fomentations failed to afford relief, and when he consulted Mr. Cooper on Monday morning, the following were the symptoms:—Acute, deep-seated pain in the eye; exquisite tenderness, especially at the upper half of the globe; great intolerance of light; profuse lachrymation; any attempt at vision produced luminous spectra; pupil contracted; iris natural; conjunctiva, but slightly injected; pulse, feeble and irritable: he complained of weakness and mental depression. He was sent to bed in a darkened room, and ordered to apply twelve leeches around the eye, to foment and take a purgative pill and dose. Mercury, he stated, always disagreed with him; and this, which is so important an auxiliary in such cases, was, therefore, obliged to be used with great caution. The next day he was rather easier; friction of the brow and temple, with mercurial ointment and opium, was directed. Pil. hydrarg. with conium, ordered at night, with salines and antimony at intervals. The following day all the symptoms were alleviated. The antimony was omitted, but the mercurials directed to be continued. On Thursday, a still greater improvement was manifested, the eye being perfectly free from pain, except when exposed to the light. There was, however, great debility and general exhaustion, and half a grain of quinine, twice a-day, with a moderate meat diet, was ordered; the mercurial friction being continued. This treatment, with counter-irritation behind the ear, and the use of a mild astringent collyrium, was steadily pursued for a week with advantage, although the least exertion of the eye immediately produced luminous spectra. The further treatment of the case presented nothing remarkable. The eye gradually and steadily recovered, and is now perfectly well.—From the state of general debility in which the system was at the time of the attack, taken in connection with the constitutional antipathy to mercury, the free exhibition of the medicine was inadmissible,—whereas the patient did perfectly well under its cautious use, the system being at the same time supported by a nutritious diet, and the careful exhibition of tonics.—*London Med. Times.*

THE PROCESS OF LABOUR.

Mr. Tyler Smith says, it may be stated briefly that labour consists of positive dilatation of the os uteri and the vagina, the action of the muscles of expiration, and contraction of the vagina; all excitomotor phenomena, aided by volition, and modified by emotion.—*Ibid.*